VIRGINIA MEDICAID
REQUEST FOR SERVICE AUTHORIZATION
FOR A
ATYPICAL ANTIPSYCHOTIC IN CHILDREN LESS THAN 6 YEARS

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Requests for service authorization (SA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**

The completed form may be **FAXED TO 800-932-6651.** Requests may be phoned to 800-932-6648.

Requests may be mailed to: Magellan Medicaid Administration / 4300 Cox Road / Glen Allen, VA 23060 / ATTN: MAP

Atypical Antipsychotic medications for individuals over 6 years of age do not require authorization.

All questions must be answered or the request will be denied

PATIENT INFORMATION	
Patient's Name:	Patient's Medicaid ID#: (12 digits)
Patient's Date of Birth:	Patient's weight in kilograms:
Are you a child/adolescent psychiatrist; pediatric neurologist; developmental/behavioral pediatrician or a pediatric neurologist? ☐ Yes ☐ No	
Has this Child had a psychiatric consultation or assessment? ☐ Yes ☐ No If Yes Date of consult:	
Indicate **X** for all diagnoses being treated:	1) Organic Psychiatric Conditions ☐ Yes ☐ No
2) Schizophrenic Disorders ☐ Yes ☐ No	3) Affective Psychoses (bipolar disorders) ☐ Yes ☐ No
4) Psychoses ☐ Yes ☐ No	5) Autism Spectrum Disorders ☐ Yes ☐ No
6) Tourette's ☐ Yes ☐ No	7) Reactive Adjustment Disorders ☐ Yes ☐ No
Or list other diagnoses that apply here	

PATIENTS CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION	
Name of program:	**Enrolled in program on:**

List pharmaceutical agents attempted and outcome:

1.
2.

If this request is denied or if more information is required; please list a phone number where you can be reached for a peer to peer consultation with the programs Board Certified Pediatric psychiatrist

PHYSICIAN INFORMATION	
Physician's Name (print):	Today's Date:
Physician's Signature:	Authorization begin date:
Physician's DEA#:	Phone #: ( )
Physician's National Provider ID#:	Fax #: ( )

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS

FAX TO 800-932-6651
SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE